SB 553 – CFI Subcommittee Work Groups

Eligibility

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Eligibility Group – Jebb Curelop

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Considerations	Recommendations	Standards	Impac
Eligibility • Length of time for eligibility determination • Gaps in eligibility caused by overdue redeterminations • Lapses result in the member reverting to fee for service (FFS) and resuming with the MCO the following month. • Clinical and financial redeterminations are not necessarily simultaneous, resulting in two different points of potential lapse. • Checking daily for eligibility is burdensome to providers.	• DHHS to continue to determine eligibility for Medicaid and CFI • Retain the language currently in Appendix B-3 b. and f., which state that there is no waiting list for the CFI program. • Create an eligibility determination timeline and track (45 days) • Synchronize clinical and financial eligibility. • Maintain MCO enrollment and coverage for full months rather than allowing an eligibility lapse result in the member's coverage moving to FFS once reinstated. • Case management involvement: • After the DO/SLRC processes an application to the CFI program, a rotation process will be used to assign a case management agency for eligibility assistance. • The case manager will assist the applicant throughout the eligibility process, which may include both Medicaid and the clinical eligibility assessment required for CFI eligibility. • Eligibility assistance will be paid under targeted case management from the date individual was assigned to the case management agency and is eligible. • This process will ensure efficiency of the eligibility process.		

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	• Case Manager has a copy of the completed MEA before first home visit (this would be an advantage of case management involvement starting with the point of application) • Dedicated DFA/DCS eligibility staff to specialize in processing applications and manage transitions to ensure prompt reinstatement of CFI eligibility post discharge from hospitals and NFs. • Allow all parties to see the member's redetermination dates and status. • Establish the ability for more than one provider to create a member roster from NHts/NHEasy. • Clinical assessments will be completed through face to face meetings with applicants/members and others as preferred by the applicant, as follows: • The initial clinical assessment will be completed as required by 151-E:3, which does not limit the professionals performing assessments to RNs. • A service assessment is completed once eligibility is established to determine the types/amounts of CFI services may most directly meet the member's needs, and is completed using a single standard tool. • The service assessment tool will be developed collaboratively by DHHS, case management agencies and MCOs.		

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	• The same service assessment tool will be used by all MCOs. • The service assessment tool will be completed and submitted to the appropriate MCO electronically. • Assessment requirements will be established in the DHHS administrative rule. • Care plans developed by the case manager will: • Have the elements defined in the administrative rule, including an acknowledgement signature from the member or legal representative. • Be standardized across all case management agencies and MCOs. • Be electronic. • Electronic practice standard for sharing information (data, service auths and utilization), • Year 1: Data points will be shared between MCOs and Agencies. • Year 2: Case Management agencies should have access to the person's MCO health record so that all aspects of their health care can be considered in the development of the Care Plan. • Ongoing: continue to develop standards and methods for electronic communication between MCOs and CMAs. Explore the applicability of Consolidated-Clinical Document Architecture.		

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Transportation • Lack of consistency in drivers for recurrent trips (including for Adult Medical Day services) • Lack of consistent communication (sometimes CTS will ask that the member or family member call for the ride instead of the agency staff) • Inconsistent authorization times- 3 months, 6 months ,one year (AMD) • Pick up and drop off times not always accurate, resulting in home care staff requiring additional time while waiting for the driver. • Transportation home from the hospital not always available. • Transportation for last minute trips that might help avoid ER use, such as to Urgent Care or the doctor's office, are not always available. Transportation Current State Concerns • Lack of consistency in drivers for recurrent trips (including for Adult Medical Day services).	• Establish standards and reimbursement that supports service delivery, for: • Emergency transportation. • Urgent transportation. For example, TN uses "required for an unscheduled episodic situation in which there is no threat to life or limb but enrollee must be seen on the day of the request." • Escort Services for people who needs assistance • Curb to curb, door to door, hand to hand (such as assisting a person with dementia who is going from and AMD to their residence and caregiver). • Routine/other transportation. • Non-medical transportation (within CFI) as approved in the member's care plan. • Require an adequate transportation network. (needs definition) • Establish acceptable time frames for scheduled rides, for example: • The member will not arrive more than 60 minutes early for an appointment and waits no more than 60 minutes after the appointment for a ride home.		

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	• Compliance monitoring will include wait times. • Improve coordination amongst hospital discharge staff for rides home. • Develop the ability to pay home care staff for time and mileage to medical appointments. • Establish a consistent transportation provider and driver for approved recurrent trips, such as to Adult Medical Day. • Allow standing orders for transportation for recurrent trips, such as daily to AMD, or to dialysis.		